

MEDICAL HISTORY- INITIAL VISIT

Patient Name: _____

Date: _____

Birth Date: _____

What is the reason for today's visit? _____

How long have you had this problem? _____

How did this problem occur? Suddenly Gradually

Is this problem a result of an injury? Yes No Work injury Car accident Other

If so, please describe the injury: _____

Which activity or position aggravates the condition most?

Sitting Standing Walking Other (please describe): _____

Which activity or position relieves the condition most?

Sitting Standing Walking Other (please describe): _____

Are there any changes in your bowel, bladder, or sexual function related to this problem? Yes No

If so, please describe: _____

Are you presently involved in a lawsuit regarding this injury? Yes No

FUNCTIONAL HISTORY:

Please describe activities you cannot perform due to this problem:

If you could choose one, most important activity you would like to get "back to," what would it be?

Have you been declared medically disabled? Yes No If so, since when? _____

Patient Name: _____

Birth Date: _____

Have you had any of the following treatments? Yes No If yes, indicate below...

Treatment	Describe	When / number of treatments / months of treatments?	Effective?	Ineffective?
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Stretching <input type="checkbox"/> Strengthening <input type="checkbox"/> Hot / cold packs <input type="checkbox"/> Electrical stim (TENS)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Occupational therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bracing			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Massage therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acupuncture			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Injections	<input type="checkbox"/> Epidural <input type="checkbox"/> Facet <input type="checkbox"/> Trigger point		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgery	<input type="checkbox"/> Neurotomy <input type="checkbox"/> Laminectomy <input type="checkbox"/> Fusion <input type="checkbox"/> Other (describe →)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you stopped any medications due to side effects? Yes No If yes, indicate below...

MEDICATION	REASON FOR STOPPING

Please list your most recent diagnostic tests. I have not had any diagnostic testing

	X-rays	MRI	Cat Scan	Discogram	Myelogram	Bone Scan	EMG	Other
Body Part								
Date								
Place								

Name: _____

Date: _____

Date of Birth: _____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in the face.

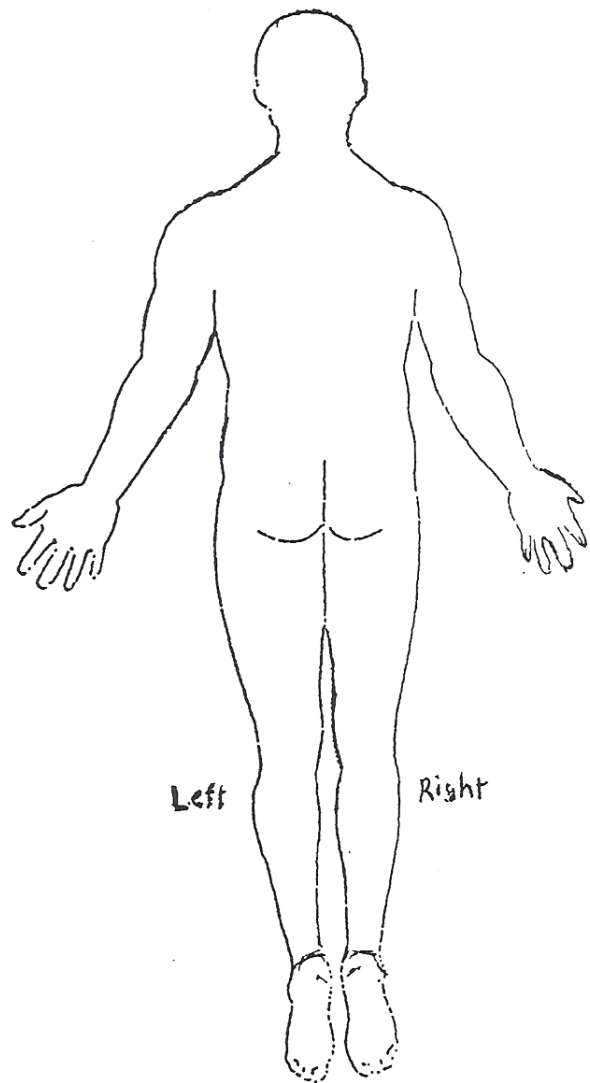
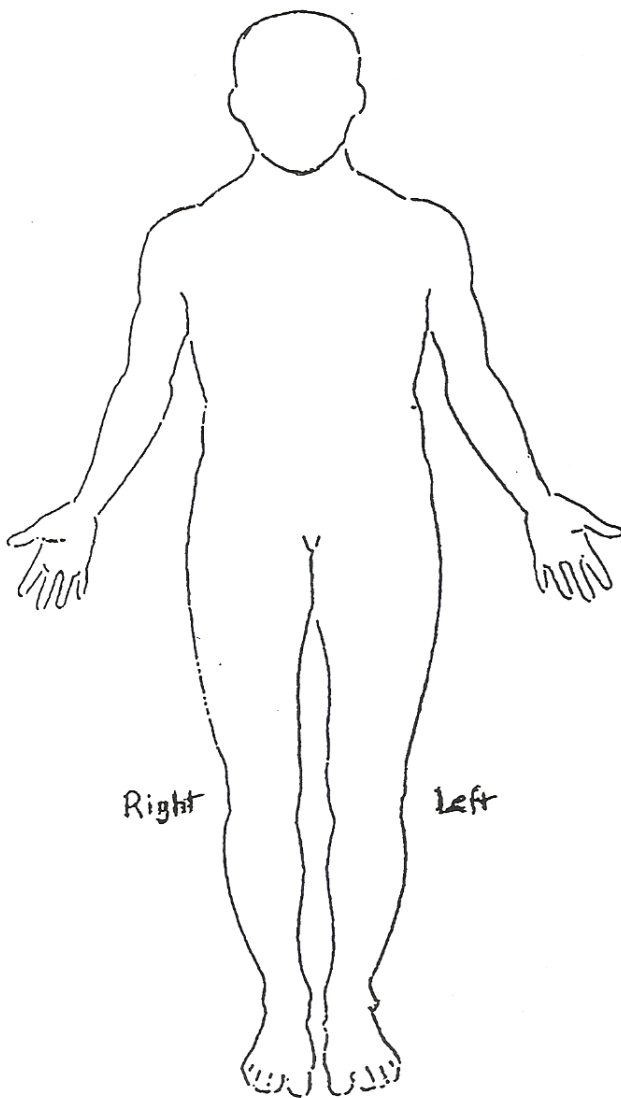
ACHE: ^ ^ ^
 ^ ^ ^
 ^ ^ ^

NUMBNESS: 0000
 0000
 0000

PINS & NEEDLES: ====
 ====
 ====

BURNING: XXXX
 XXXX
 XXXX

STABBING: ///
 ///
 ///



HOW BAD IS YOUR PAIN?

No Pain |-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst Possible

PLEASE MARK THE LINE WITH AN X INDICATING YOUR DEGREE OF PAIN

PATIENT'S SIGNATURE: _____

Referral & Contact Information

Patient Name: _____

Date of Birth: _____

Phone Contact Information:

Home Phone: () _____ OK to leave a message? Yes No

Cell Phone: () _____ OK to leave a message? Yes No

Work Phone: () _____ OK to leave a message? Yes No

Referral Information:

1. How did you learn about Spine & Sports Physiatrists? (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Elmhurst Hosp Referral Line | <input type="checkbox"/> Insurance Carrier |
| <input type="checkbox"/> Family Member/Friend | <input type="checkbox"/> Hinsdale Hosp Referral Line | <input type="checkbox"/> Case Manager |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> GlenOaks Hosp Referral Line | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Other: _____ | | |

2. Who is your primary care physician?

Name: _____

Specialty: _____

Address: _____

Telephone: _____ Fax: _____

3. Who referred you for this evaluation (if different than your primary care physician)?

Name: _____

Specialty: _____

Address: _____

Telephone: _____ Fax: _____